MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9320 **CERTIFICATE OF DEATH** 09326

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5yrs.8mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: formerly of: 1829 N. Dallas Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma — Middle J. — Last ANDERSON

4. DATE OF DEATH: Month September — Day 13, — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 24, 1856
9. AGE (In years last birthday): 101 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Holler Anderson
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile psychosis, simple deterioration. Fractured pubic bone.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 14, 1952, to September 13, 1957, that I last saw the deceased alive on September 12, 1957, and that death occurred at 1:12A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/13/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/16/57
22c. NAME OF CEMETERY OR CREMATORY: Green Mount Cem.
22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm. J. Tickner & Sons - Baltimore Md
24a. RECD BY REGISTRAR DATE: SEP 16 1957
24b. REGISTRAR'S SIGNATURE: Harry Keys

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9321

CERTIFICATE OF DEATH

09327

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Sykesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Olivia — Middle: Florence — Last: Appleby

4. DATE OF DEATH: Month: Sept — Day: 25 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 2-28-1874

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles M. Kibbey

14. MOTHER'S MAIDEN NAME: Sarah L. Ridley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Daughter — Address: Mrs Hardy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest, bronchial — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
334X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) pneumonia, arteriosclerosis, hypertension — June 57 to
DUE TO
(c) Left hemiplegia — Sept 57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1954, 19___, to Sept, 1957, that I last saw the deceased alive on 25 Sept, 1957, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E Hall M.D. — ADDRESS (Street, city or town, state): Sykesville, Md — DATE SIGNED: 25 Sept 57

PHYSICIAN'S NAME (Type): HOWARD E. HALL — SYKESVILLE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-28-57

22c. NAME OF CEMETERY OR CREMATORY: Providence

22d. LOCATION (City, town, or county) (State): Elkridge, Howard, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haslet — ADDRESS: Sykesville Md

24a. REC'D BY REGISTRAR DATE: 9-26-57

24b. REGISTRAR'S SIGNATURE: C. Nancy Greer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9322 Item 7 FilmG220 9-30-57 et

Items 8 & 9 G221 10/15/57 GE

CERTIFICATE OF DEATH

09328 74

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.9mos.25days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 yrs 1 4
d. STREET ADDRESS: 1824 E. Pratt Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: — Last: BARAN

4. DATE OF DEATH: Month: September — Day: 18, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 18, 1887 (1886)

9. AGE (In years last birthday): 70 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Andrew Baran

14. MOTHER'S MAIDEN NAME: Mary Baran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenocarcinoma of the rectum — INTERVAL BETWEEN ONSET AND DEATH: Approx. 2 yrs.
154X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with alcohol intoxication with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 23, 1955, to September 18 1957, that I last saw the deceased alive on September 17, 1957, and that death occurred at 8:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/18/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/21/57
22c. NAME OF CEMETERY OR CREMATORY: HOLY ROSARY
22d. LOCATION (City, town, or county) (State): BALTIMORE Md

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Patronski — ADDRESS: 2818 E. Balto. St

24a. REC'D BY REGISTRAR DATE: SEP 24 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Keers

SEP 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9323

CERTIFICATE OF DEATH

09329
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 21 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 508 Cording Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Catherine Margaret Miller — Middle — Last: BEVANS

4. DATE OF DEATH: Month: September — Day: 10 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 23, 1875

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — Interval between onset and death: Unknown
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — Unknown
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with senile brain disease, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 19, 1957, to Sept. 10, 1957, that I last saw the deceased alive on Sept. 9, 1957, and that death occurred at 8:20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/10/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-13-57
22c. NAME OF CEMETERY OR CREMATORY: Parkwood
22d. LOCATION (City, town or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lemard J Luck
ADDRESS: 305 Harford

24a. REC'D BY REGISTRAR DATE: 9-10-57
24b. REGISTRAR'S SIGNATURE: C Harry Kier

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9324 — 09330 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8 m 11 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18, — 3701-H
d. STREET ADDRESS: 2307 Aisquith Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

3. NAME OF DECEASED (Type or print): First: Noble — Middle: — Last: Biscoe

4. DATE OF DEATH: Month: 9 — Day: 22 — Year: 19 57

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 3-9-93 — 9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): auto salesman — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Biscoe — 14. MOTHER'S MAIDEN NAME: Martha Dickerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-6636

17. INFORMANT — Address: S.S.Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ~~Cerebral~~ Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: Hours

936.1

DUE TO (b): Fracture left femur — 12 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. brain syndr.assoc.with psychotic reaction of unknown cause

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Do not Know

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: 9-10 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Springfield State Hosp. — 20f. (City or town): Sykesville — (County): Carroll — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh — M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9-22-57

EXAMINER'S NAME (Type): James T. Marsh

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept 25 — 22c. NAME OF CEMETERY OR CREMATORY: Shedlersville — 22d. LOCATION (City, town, or county): Shedlersville — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar A. Lowe — ADDRESS: Church Hill

24a. REC'D BY REGISTRAR — DATE: SEP 26 1957 — 24b. REGISTRAR'S SIGNATURE: C. H. Weer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09331

93?5

Reg. Dist. No. 8W

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR
c. LENGTH OF STAY IN 1b YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HOWARD Middle Last BLACKSTEN
4. DATE OF DEATH Month SEPT Day 14 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH APRIL 8 - 1879
9. AGE (In years last birthday) 78 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER
10b. KIND OF BUSINESS OR INDUSTRY OWN FARM
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN H BLACKSTEN
14. MOTHER'S MAIDEN NAME LIZA HAWK
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO NONE
17. INFORMANT Address WILBUR BLACKSTEN NEW WINDSOR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation - by hanging

DUE TO (b) Suicide -

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE S. Luther Bare ____ M.D.
EXAMINER'S NAME (Type) S. LUTHER BARE
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 9/16/57

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF SEPT 17-1957
22c. NAME OF CEMETERY OR CREMATORY PIPE CREEK
22d. LOCATION (City, town, or county) CARROLL CO (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS D D Hartzler & Sons New Windsor
24a. REC'D BY REGISTRAR DATE Sept 18/57
24b. REGISTRAR'S SIGNATURE Erwin L Benedict
Deputy Reg.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09332

9326

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1 PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester (Rural)
c. LENGTH OF STAY IN 1b 17 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester (Rural)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Joseph Middle H. Last Bradshaw

4. DATE OF DEATH Month Sept Day ✓ Year 1957

5. SEX M

6. COLOR OR RACE W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH Mar 28 - 1870

9. AGE (In years last birthday) 87 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Farmer

11. BIRTHPLACE (State or foreign country) North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Bradshaw

14 MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16 SOCIAL SECURITY NO. 219-14-8848

17. INFORMANT Address Mrs Mamie Bradshaw Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH 6 Months

153X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/22/ 1947, to 9/5/ 1957, that I last saw the deceased alive on Sept 1 1957, and that death occurred at 1130 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE W H Foard M.D. ADDRESS (Street, city or town, state) Manchester, Md DATE SIGNED 9/6/57

PHYSICIAN'S NAME (Type) W. H. Foard M. D. Manchester, Md

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF 9/9/57

22c NAME OF CEMETERY OR CREMATORY Manchester

22d LOCATION (City, town or county) (State) Carroll Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edw C Tipton ADDRESS Hampstead Md

24a REC'D BY REGISTRAR DATE Sept 9/57

24b REGISTRAR'S SIGNATURE Mrs. H. P. Dennis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9327 CERTIFICATE OF DEATH

Reg. Dist. No. 09333 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 13 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 17 Philadelphia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: Neff — Last: BROUNER

4. DATE OF DEATH: Month: September — Day: 17, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 27, 1869

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: GEN. BLDG. TRADES

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: ~~Unknown~~ RICHARD RUSSELL BROUNER

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ ANNIE DRAYTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

DUE TO (b): Hypertension — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Nephrosis — Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with cerebral arteriosclerosis, psychotic reaction. Diabetes Mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 4, 1957, to September 17 1957, that I last saw the deceased alive on September 17, 1957, and that death occurred at 12:50 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/17/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 19, 1957

22c. NAME OF CEMETERY OR CREMATORY: DUNMORE CEMETERY

22d LOCATION (City, town, or county): SCRANTON. (State): PENNA

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: WASH 12, D C 537 5th WEST NW

24a. REC'D BY REGISTRAR: SEP 19 19

24b. REGISTRAR'S SIGNATURE: C Harry Keen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09334

9328

Reg. Dist. No. 81

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION BRIDGE, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Pa. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Greencastle
d. STREET ADDRESS: RD1 - Greencastle, Pa.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle W — Last BRYAN

4. DATE OF DEATH: Month Sept — Day 27 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 15, 1896

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Electrical Work

11. BIRTHPLACE (State or foreign country): Marion, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Bryan

14. MOTHER'S MAIDEN NAME: Harriett GRIMES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No —

16. SOCIAL SECURITY NO: 223-28-1872

17. INFORMANT: Mrs. Anna Bryan — Address: RD1 Greencastle Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: MIN.

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/27/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/30/57

22c. NAME OF CEMETERY OR CREMATORY: Macedonia Cem.

22d. LOCATION (City, town, or county) (State): Franklin Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: A.E. Minnich — ADDRESS: Greencastle Pa.

24a. REC'D BY REGISTRAR — DATE: SEP 30 1957

24b. REGISTRAR'S SIGNATURE: Leslie L Repp

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9329 **CERTIFICATE OF DEATH**

Reg. Dist. No. 09335 81

1. PLACE OF DEATH
a. COUNTY CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE
c. LENGTH OF STAY IN 1b YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE
d. STREET ADDRESS RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First DAISY Middle MAY Last COLEMAN

4. DATE OF DEATH Month SEPT. Day 25 Year 1957

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 12/24/1868
9. AGE (In years last birthday) 88 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME GEORGE ANGELL
14. MOTHER'S MAIDEN NAME SARAH JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO NONE
17. INFORMANT RENO COLEMAN Address KEYMAR, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan —, 1957, to 9-25-, 1957, that I last saw the deceased alive on 9-21-, 1957, and that death occurred at 12 NOON from the causes and on the date stated above.

ACTUAL SIGNATURE D. H. Legg M.D. ADDRESS (Street, city or town, state) Union Bridge DATE SIGNED 9-25-57

PHYSICIAN'S NAME (Type) Thomas H. Legg, M.D. Union Bridge, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 9/28/57
22c. NAME OF CEMETERY OR CREMATORY PIPE CREEK
22d. LOCATION (City, town, or county) (State) CARROLL COUNTY MD

23. FUNERAL DIRECTOR'S SIGNATURE O. O. Harbaugh Sons ADDRESS Union Bridge Md.
24a. REC'D BY REGISTRAR DATE 9/28/57
24b. REGISTRAR'S SIGNATURE Leslie L. Reifsnyder

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9330

093364
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.6mos.14days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter — Middle Davis — Last COURTNEY

4. DATE OF DEATH: Month September — Day 16, — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. [redacted] DIVORCED ☒

8. DATE OF BIRTH: May 13, 1877

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR / IF UNDER 24 HRS — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James D. Courtney

14. MOTHER'S MAIDEN NAME: Catherine Courtney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombocytopenia purpura — INTERVAL BETWEEN ONSET AND DEATH: Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) [redacted] Arteriosclerotic heart disease — Years

DUE TO

(c) Generalized arteriosclerosis — Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with dist.of metabolism,growth or nutrition,with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 2, 1956, to September 16, 1957, that I last saw the deceased alive on September 16, 1957, and that death occurred at 9:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/16/57

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-19-1957

22c. NAME OF CEMETERY OR CREMATORY: mt. Olivet Cemetery

22d LOCATION (City, town, or county) (State): Frederick - Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. E. Cline & Son W. — ADDRESS: Frederick-Md.

24a REC'D BY REGISTRAR — DATE: 9-17-57

24b REGISTRAR'S SIGNATURE: Harry C. Weer

EJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9331 — 09337 — Reg. Dist. No. 77

Item 8 Grave 9/20/57

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ✓

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
d. STREET ADDRESS: ✓
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First L. — Middle KURTZ — Last CULLISON
4. DATE OF DEATH: Month Sept — Day 18 — Year 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 17-1875
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Geo R Cullison
14. MOTHER'S MAIDEN NAME: Rachel Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-22-5454
17. INFORMANT — Address: Mrs James Harris, Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Sclerotic Coronary Disease & Angina — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1947, to Sept. 18, 1957, that I last saw the deceased alive on Sept. 16, 1957, and that death occurred at 1:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M.C. Porterfield M.D.
ADDRESS (Street, city or town, state): Hampstead, Md
DATE SIGNED: 9/20/57
PHYSICIAN'S NAME (Type): M.C.Porterfield, M.D. — Hampstead, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-22-57
22c. NAME OF CEMETERY OR CREMATORY: Sweet Meth.
22d. LOCATION (City, town, or county) (State): Balto Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Edw L Tipton, Hampstead Md
24a. REC'D BY REGISTRAR DATE: 9/27/57
24b. REGISTRAR'S SIGNATURE: Henry L Davis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9332

09338 74 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2mos.15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1904 Barclay Street, Baltimore 18
d. STREET ADDRESS: 1904 Barclay Street, Balto. 18.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sadie Middle Jane Last DAHL

4. DATE OF DEATH: Month September Day 30, Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 6, 1890
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days / IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph E. Dolan
14. MOTHER'S MAIDEN NAME: Annie Pyle

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: -
17. INFORMANT: Springfield State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — Interval between onset and death: Years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Involutional psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 1957, to September 30 1957, that I last saw the deceased alive on September 30, 1957, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/30/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 4-1957
22c. NAME OF CEMETERY OR CREMATORY: MT. CARMEL
22d. LOCATION (City, town, or county) (State): BALTO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Gehrs & Connelly — ADDRESS: Essex 21 Md.
24a. RECD BY REGISTRAR DATE: OCT 3 1957
24b. REGISTRAR'S SIGNATURE: C.H Green

E 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15 9/

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09339

CERTIFICATE OF DEATH

9333

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b: 4/ YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
d. STREET ADDRESS: 109 LIBERTY ST EXT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First VLYSSES Middle SIMPSON Last EBAUGH

4. DATE OF DEATH: Month SEPTEMBER Day 21 Year 1957

5. SEX: MALE

6. COLOR OR RACE: CAUC.

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 2, 1877

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELLER-BANKING (RETIRED)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: JOEL EBAUGH

14. MOTHER'S MAIDEN NAME: SARAH ROUTSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-03-4035

17. INFORMANT: WIFE — Address: 109 LIBERTY ST EXT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 4 WEEKS
422.1
DUE TO (b): ARTERIO-SCLEROTIC CARDIOVASCULAR DIS. — 2 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.: ~~3:30 p.m. SEPT 21 1957~~

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY 20, 1957, to SEPT 21, 1957, that I last saw the deceased alive on SEPT 20, 1957, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David I. Wellers M.D.
ADDRESS (Street, city or town, state): 19 N. CHURCH ST WESTMINSTER MARYLAND
DATE SIGNED: 9/21/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT 23 57
22c. NAME OF CEMETERY ~~OR CREMATORY~~: CARROLLTON CEM.
22d. LOCATION (City, town, or county) (State): RURAL WESTMINSTER, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster Md
24a. REC'D BY REGISTRAR DATE: 9-22-57
24b. REGISTRAR'S SIGNATURE: Harriet Butler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9334 **CERTIFICATE OF DEATH** 09340

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield State Hospital
c. LENGTH OF STAY IN 1b: 4yrs.5mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sykesville, Maryland

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2728 Winchester Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret Middle Vincent Last ELLIOTT

4. DATE OF DEATH: Month September Day 11, Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 13, 1879
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert O. Elliott
14. MOTHER'S MAIDEN NAME: Catherine Philpot

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Inanition with edema — INTERVAL BETWEEN ONSET AND DEATH: Weeks
539.1
DUE TO (b): Esophageitis — Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile psychosis, agitated depressed type, plus diabetes.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 12, 1952, to September 11 1957, that I last saw the deceased alive on September 11, 1957, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 9/11/57

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 14/57
22c. NAME OF CEMETERY OR CREMATORY: Cathedral
22d. LOCATION (City, town, or county) (State): Woodlawn '29

23. FUNERAL DIRECTOR'S SIGNATURE: Stewart McDonald ADDRESS: 128 W. North Balto
24a. REC'D BY REGISTRAR DATE: 9/11/57
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9335

09341

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JANE — Middle E. — Last EVANS

4. DATE OF DEATH: Month Sept. — Day 13 — Year 1957

5. SEX: F. — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Aug. 25, 1888 — 9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b KIND OF BUSINESS OR INDUSTRY: Home — 11. BIRTHPLACE (State or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Woodward — 14 MOTHER'S MAIDEN NAME: Ida Grimm

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service) — 16 SOCIAL SECURITY NO.: None — 17. INFORMANT: Robert Evans — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac arrest, Asterosclerosis — INTERVAL BETWEEN ONSET AND DEATH

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Cerebral thrombosis, Auricular fibrillation, — 1954 to Sept 57

DUE TO (c): Diabetes,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1954, 19__, to Sept, 1957, that I last saw the deceased alive on 13 Sept, 1957, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E. Hall M.D. — ADDRESS (Street, city or town, state): Sykesville, Md — DATE SIGNED: 13 Sept 57

PHYSICIAN'S NAME (Type): HOWARD E. HALL — Sykesville, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9-15-57 — 22c NAME OF CEMETERY OR CREMATORY: Morgan Chapel — 22d. LOCATION (City, town, or county) (State): Woodbine, Howard, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md. — 24a. REC'D BY REGISTRAR DATE: 9-14-57 — 24b REGISTRAR'S SIGNATURE: C. Harry Eder

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9336

CERTIFICATE OF DEATH

09342 14

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 6 y 10 m 4 d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14, Md.
d. STREET ADDRESS 3202 Hamilton Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle Francis Last Evans
4. DATE OF DEATH: Month 9 Day 21 Year 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-12-1900
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician
10b. KIND OF BUSINESS OR INDUSTRY: Uncle
11. BIRTHPLACE (State or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Francis Evans
14. MOTHER'S MAIDEN NAME: Florence Manchester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) 11/12/42-2/17/43
16. SOCIAL SECURITY NO. 216-01-4473
17. INFORMANT: Address: Hospital Records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pharynx — INTERVAL BETWEEN ONSET AND DEATH: 5 months plus

148X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with chronic alcoholic deterioration 3 1X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-20-54, 19__, to 9-20-, 1957, that I last saw the deceased alive on 9-20-, 1957, and that death occurred at 1:59 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B Lusthaus M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 9-21-57

NAME (Type): Edmund B. Lusthaus Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-25-57
22c. NAME OF CEMETERY OR CREMATORY: National
22d. LOCATION (City/town or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Sander & Son ADDRESS: North Ave & Broadway
24a. REC'D BY REGISTRAR DATE: 9-23-57
24b. REGISTRAR'S SIGNATURE: C. Henry Eden

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9337 — 09343 — Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 81 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hosp. ind

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 27, 14
d. STREET ADDRESS: 3409 Greenway St. Balto 18
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cleautha — Middle: Marie — Last: Everitt

4. DATE OF DEATH: Month: September — Day: 21 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-4-1876

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John [redacted] GREASEN

14. MOTHER'S MAIDEN NAME: Mary Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No Unknown

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Mrs G. Wharton Brown-3409 Greenway St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): due to Hypertensive Cardiovascular disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-23-57, 19 57, to 9-21, 19 57, that I last saw the deceased alive on 9-21, 19 57, and that death occurred at 7:45 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrud Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital Sykesville Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Gertrud Sonnenfeldt M.D. — Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/24/57
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm J. Tschiew & Sons — ADDRESS: Catonsville Md.

24a. REC'D BY REGISTRAR DATE: 9/24/57

24b. REGISTRAR'S SIGNATURE: C Harry Heer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09344

Reg. Dist. No. 26

9338

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Westminster
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Westminster RD 7

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Westminster
d. STREET ADDRESS: Westminster RD 7
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle GATELY — Last FLYNN

4. DATE OF DEATH: Month Sept. — Day 3 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 12, 1900
9. AGE (In years last Birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William L. Flynn
14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Gately Flynn, Westminster, Md. RD 7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Arteriosclerotic cardiovascular disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Russell S Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 9/4/57
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 6 57
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Medford Branch
22d. LOCATION (City, town, or county) (State): Westminster, Md. RD

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. E. Myers Jr. Westminster Md.
24a. REC'D BY REGISTRAR — DATE: 9-5-57
24b. REGISTRAR'S SIGNATURE: Hannet Bills

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9339

09345

Reg. Dist. No. 60

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TANEYTOWN
c. LENGTH OF STAY IN 1b: MINUTES
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MAIN STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ NEW WINDSOR RURAL
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First VIOLET Middle KOONS Last FUSS

4. DATE OF DEATH: Month SEPT Day 15 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOV 1 - 1889

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN M KOONS

14. MOTHER'S MAIDEN NAME: ELNORE M HANN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-14-7951

17. INFORMANT: MAUDE KOONS Address: NEW WINDSOR RURAL MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Min

DUE TO (b): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ___

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a. m. p. m. Month, Day, Year 19___

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James J Mood M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/15/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT 18-1957

22c. NAME OF CEMETERY OR CREMATORY: REFORMED

22d. LOCATION (City, town, or county) (State): TANEYTOWN MD

23. FUNERAL DIRECTOR'S SIGNATURE: D D Hartzler & Sons ADDRESS: New Windsor Md

24a. REC'D BY REGISTRAR: Dec 16 1957

24b. REGISTRAR'S SIGNATURE: Erma Benedict

2nd.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9340 — 09346 — Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
c. LENGTH OF STAY IN 1b: 14 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SPRINGFIELD STATE H.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 18, 3701-4
d. STREET ADDRESS: 1525 NORTHGATE Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA — Middle FLORENCE — Last CARTON
4. DATE OF DEATH: Month SEPT — Day 13 — Year 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: V-19-78
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY C. SCHLUETER
14. MOTHER'S MAIDEN NAME: Anna Brenker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ANNA CARTON CORDETT; Address: AS ADAUT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULA
DUE TO
(b) DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 15 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS ASSOCIATED W SENILE BRAIN DISEASE, W PSYCHOTIC REACTION
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from VII-6, 56, 19__, to IX-15, 1957, that I last saw the deceased alive on IX-15, 1957, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrud Sommerfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital Sykesville Md. — DATE SIGNED
PHYSICIAN'S NAME (Type): Gertrud Sommerfeldt M.D. Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/18/57
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
22d. LOCATION (City, town, or county) (State): Pikesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Sons - Bal 6, 17 Md. — ADDRESS
24a. RECD BY REGISTRAR: SEP 16 1957 — DATE
24b. REGISTRAR'S SIGNATURE: C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09347

9341

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 7 MO.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Long View Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glyndon
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle — Last GORMAN

4. DATE OF DEATH: Month September Day 27 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 2, 1888

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAID

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): SCOTLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Daniel Gorman

14. MOTHER'S MAIDEN NAME: Ellen Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs John K. Shaw Jr; Glyndon MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Anterior Myocardial Infarction — 1954

DUE TO

(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19—

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) — (County) — (State)

21. I certify that I attended the deceased from Feb 2, 1957, to Sept 27, 1957, that I last saw the deceased alive on Sept 24, 1957, and that death occurred at 12:20 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Bush M.D. — ADDRESS (Street, city or town, state): Hampstead md — DATE SIGNED: 9/27/57

PHYSICIAN'S [illegible] (Type): Joseph E. Bush MD — Hampstead Maryland

22a. BURIAL, CREMATION, REMOVAL (specify): Burial

22b. DATE THEREOF: Sept 30/57

22c. NAME OF CEMETERY OR CREMATORY: St Johns Cath.

22d. LOCATION (City, town, or county) (State): Westminster Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw S Tipton — ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: Sept 29/57

24b. REGISTRAR'S SIGNATURE: Mrs. WRS-Dennes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09348

9342

CERTIFICATE OF DEATH

Reg. Dist. No. 8Y

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
c. LENGTH OF STAY IN 1b: 28 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
d STREET ADDRESS: Church St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle FRANK Last HARRIS, SR

4. DATE OF DEATH: Month 9- Day 10- Year 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-16-1896
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Garage
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Scheel Harris
14 MOTHER'S MAIDEN NAME: Rovella Hare

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 213-36-7613
17. INFORMANT: Mrs. Marion Harris, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Throat — INTERVAL BETWEEN ONSET AND DEATH
140 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 57, to Sept 10, 19 57, that I last saw the deceased alive on Sept 10, 19 57, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C M Van Poole M.D. ADDRESS (Street, city or town, state): Mt Airy Md DATE SIGNED: 9-10-57

PHYSICIAN'S NAME (Type): C M Van Poole

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9-12-1957
22c. NAME OF CEMETERY: Baltimore National
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Md.
24a. REC'D BY REGISTRAR DATE: SEP 13 1957
24b. REGISTRAR'S SIGNATURE: Mrs. Robt Stewart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove pages 3 and 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9343 — 09349 — Reg. Dist. No. 33

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown RD3
c. LENGTH OF STAY IN 1b: 10 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Emory Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/Reisterstown Rd 3
d. STREET ADDRESS: Emory Rd.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Jacob — Middle: A. — Last: Helwig

4. DATE OF DEATH: Month: Sept. — Day: 13 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 24, 1874

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John O. Helwig

14. MOTHER'S MAIDEN NAME: Marget Vance

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-20-7445

17. INFORMANT — Address: Mrs. Dora Helwig, Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C.-V. Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hemiplegia — 2½ mos.

DUE TO

(c) Multiple bed sores — 1 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): none

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: none

20d. INJURY OCCURRED While at work ☐ Not while at work ☐: none

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) (County) (State): none

21. I certify that I attended the deceased from 1-5-45, 19____, to 9-13-57, 19____, that I last saw the deceased alive on 9-12-57, 19____, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: D. D. Caples M.D. — ADDRESS (Street, city or town, state): 6 Hanover Rd. — DATE SIGNED: 9-16-57

PHYSICIAN'S NAME (Type): D. D. Caples, M. D. — Reisterstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 16/57
22c. NAME OF CEMETERY OR CREMATORY: Finksburg Cemetery
22d. LOCATION (City, town, or county) (State): Finksburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J.F.Eline & Sons Reisterstown, Md.

24a. REC'D BY REGISTRAR DATE: 9-16-57

24b. REGISTRAR'S SIGNATURE: Harriet L Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9344

CERTIFICATE OF DEATH

09350

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 808 S. Belnord Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle S. — Last HOKE

4. DATE OF DEATH: Month September — Day 25, — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-24-96

9. AGE (In years last birthday): 61 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes — If yes, give war or dates of service: World War 1

16. SOCIAL SECURITY NO.: 217-09-3879

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours
420.0
DUE TO (b): Arteriosclerotic heart disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalized Arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome of unknown cause.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 17, 1957 to September 25 1957 that I last saw the deceased alive on September 24, 1957, and that death occurred at 3:10A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/25/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-27-1957

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Raymond L. Kaczorowski — 2525 Fleet Street

24a. REC'D BY REGISTRAR — DATE: SEP 30 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9345 **CERTIFICATE OF DEATH** 09351 81 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LOCUST ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: LOCUST ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First FANNIE Middle L. Last HOUCK

4. DATE OF DEATH: Month SEPT Day 12 Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/25/1887

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JACOB R HOUCK

14. MOTHER'S MAIDEN NAME: MARY JANE HOUCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: Address: REV W. HOUCK, DETOUR, MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac Occlusion
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-1- 19 57, to 9-12- 19 57, that I last saw the deceased alive on 9-12- 19 57, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: D. N Legg M.D. ADDRESS (Street, city or town, state): Union Bridge, Md DATE SIGNED: 9-11-57

PHYSICIAN'S NAME (Type): Thomas H. Legg M.D. Union Bridge, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9/15/57

22c. NAME OF CEMETERY OR CREMATORY: MT. HOPE CEM.

22d. LOCATION (City, town, or county) (State): WOODSBORO, MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: D.D. Hutchinson UNION BRIDGE, MD

24a. REC'D BY REGISTRAR DATE: 9/14/57

24b. REGISTRAR'S SIGNATURE: Leslie L. Reifsnyder

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9346 CERTIFICATE OF DEATH

Reg. Dist. No. 093574

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: Boone's Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: John — Last: Howard

4. DATE OF DEATH: Month: 9 — Day: 7 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: ~~unkn~~ 7/5/1872

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unkn — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 228-44-7537

17. INFORMANT: U.S. Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. brain syndr. assoc. with arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, a.m., p.m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-13-, 1957, to 9-6-, 1957, that I last saw the deceased alive on 9-6-, 1957, and that death occurred at 6:23 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lustbaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9-7-57

PHYSICIAN'S NAME (Type): Edmund Lustbaus — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9-9-57 — 22c. NAME OF CEMETERY OR CREMATORY: Pleasant Hill — 22d. LOCATION (City, town, or county) (State): Monrovia, Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F.C. Higinbothom, Ellicott City, Md

24a. RECEIVED BY REGISTRAR, DATE: SEP 10 1957 — 24b. REGISTRAR'S SIGNATURE: C. Harry Mays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

Item 20b Film 220

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09353

Reg. Dist. No. 74

9347

Field	Entry
1. PLACE OF DEATH a. COUNTY	Carroll, MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)	Sykesville
c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Bartholow Road
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	Maryland
b. COUNTY	Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Marriottsville
d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM?	YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First / Middle / Last	BERNARD CARL JACKSON
4. DATE OF DEATH Month / Day / Year	Sept.1,1957 19
5. SEX	Male
6. COLOR OR RACE	Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	Never married
8. DATE OF BIRTH	4-12-1945
9. AGE (In years last birthday)	12 yrs.
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Student
10b. KIND OF BUSINESS OR INDUSTRY	None
11. BIRTHPLACE (State or foreign country)	Baltimore,Md
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	Carl Hodge
14. MOTHER'S MAIDEN NAME	Ethel Robinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	No
16. SOCIAL SECURITY NO	None
17. INFORMANT / Address	Ethel Jackson,Marriottsville,Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Frac Skull — Multiple frac

813 X

DUE TO (b) Left femur

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Rode his bicycle into an automobile

20c. TIME OF INJURY Hour 12:15 p m; Month, Day, Year 9-1 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bartholow Road

20f (City or town) Sykesville (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James T. Marsh M.D.

EXAMINER'S NAME (Type) JAMES T MARSH

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 9/1/57

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9-4-57	West Liberty	Alpha,Md

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
F.C.Higinbothom,Ellicott City,Md.	SEP 3 1957	C. Harry Heers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9348

CERTIFICATE OF DEATH

09354 Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
d. STREET ADDRESS: Eldersburg. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pamela — Middle: — Last: JOHNSON

4. DATE OF DEATH: Month: 9 — Day: 14 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 30 1955

9. AGE (In years last birthday): 2 yrs
IF UNDER 1 YEAR: Months: — Days: 15
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank T Johnson

14. MOTHER'S MAIDEN NAME: Phyllis Brandhurst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: None

17. INFORMANT: Address: Mr. Frank T Johnson - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Gastro - Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

756.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): cirrhosis of liver and spleen — 2 years

DUE TO (c): aplasia of bile ducts — congenital

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-17, 19 55, to 9-14, 19 57, that I last saw the deceased alive on 9-14, 19 57, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bertram R Gau M.D. — ADDRESS (Street, city or town, state): SYKESVILLE Md. — DATE SIGNED: 9-15-57

PHYSICIAN'S NAME (Type): Bertrand R GAU

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-17-57

22c. NAME OF CEMETERY OR CREMATORY: Freedom

22d. LOCATION (City, town, or county) (State): Eldersburg (Carroll) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H Haight — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: 9-16-57

24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09355 40

9349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LINWOOD
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XI LINWOOD
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FANNIE Middle ELLEN Last JONES

4. DATE OF DEATH: Month SEPT Day 12 Year 1957

5. SEX: F

6. COLOR OR RACE: COL

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEB 29-1875

9. AGE (In years last birthday): 82 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LAUNDRESS

10b. KIND OF BUSINESS OR INDUSTRY: LAUNDRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN DAVIS

14. MOTHER'S MAIDEN NAME: ELLEN TUCKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MRS HOWARD DAVIS UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): arteriosclerotic Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/13/57, 19____, to 9/12/57, 19____, that I last saw the deceased alive on 9/7/57, 19____, and that death occurred at 5 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D. ADDRESS (Street, city or town, state): New Windsor, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT 15-1957

22c. NAME OF CEMETERY OR CREMATORY: MT JOY

22d. LOCATION (City, town, or county) (State): UNIONTOWN MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: D D Hartzler & Sons New Windsor, Md

24a. REC'D BY REGISTRAR DATE:

24b. REGISTRAR'S SIGNATURE: Gracie Benedum

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9350 **CERTIFICATE OF DEATH** Reg. Dist. No. 09356 16

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carrollton Rural
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Dutrow Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carrollton Rural
d. STREET ADDRESS: Dutrow Rd
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: ALEXANdria (Alice) Middle: — Last: KIAUNIS
4. DATE OF DEATH: Month: September Day: 7 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 2, 1881
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Francis Baravickas
14. MOTHER'S MAIDEN NAME: Helen Bejaikis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Helen Jakimonis Address: Carrollton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Carcinoma Lung. — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Primary Carcinoma of Pancreas
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) (County) (State): —

21. I certify that I attended the deceased from Aug 7, 19 57 to Sept 7, 19 57 that I last saw the deceased alive on Sept 5, 19 57, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Bush M.D. ADDRESS (Street, city or town, state): Hampstead Md DATE SIGNED: 9/7/57
PHYSICIAN'S NAME (Type): Joseph E. Bush MD Hampstead Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/10/57
22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
22d. LOCATION (City, town, or county) (State): 4430 Belair Rd

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Cowan & Son ADDRESS: 76 Collins St.
24a. REC'D BY REGISTRAR DATE: SEP 9 1957
24b. REGISTRAR'S SIGNATURE: Arnett Riley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/SS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The burial permit copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9351

CERTIFICATE OF DEATH

09357

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor

LENGTH OF STAY (in this place): Years

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Carroll

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor

STREET (If rural give location): [redacted]

3. NAME OF DECEASED (Type or Print): (First) EDGAR (Middle) WILLIAM (Last) KOONTZ

4. DATE OF DEATH (Month) Sept. (Day) 19 (Year) 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	June 18, 1899	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Building	Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Milton Koontz	Annie Snook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	No	214-28-2217	Reta H. Koontz, New Windsor, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic C.V. disease — 2 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July ....., 19 56, to Sept 11 ....., 19 57, that I last saw the deceased alive on Sept 15 ....., 19 57, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE: James J. Marsh M.D. — ADDRESS (Street, city, town, state): Westminster Md — DATE SIGNED: 9/21/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/22/57	Winters Cemetery	Carroll County, Md.

24. REC'D BY REGISTRAR (Date)	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
Sept 23/57	Grace L. Benedict Asst. Reg.	D. D. Hershey Sons	New Windsor, Md.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9352

CERTIFICATE OF DEATH

Reg. Dist. No. 09358

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
c. LENGTH OF STAY IN 1b: 11 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Niner Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Finksburg
d. STREET ADDRESS: Niner Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Esther Middle Louise Last Lentzner
4. DATE OF DEATH: Month Sept. Day 25 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 26, 1917
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. County, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Lenwood Cross
14. MOTHER'S MAIDEN NAME: Gertrude Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO: - - - - - -
17. INFORMANT: James Z. Lentzner Address: Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/25 19 57 to 9/25 19 57 that I last saw the deceased alive on 9/25 19 57 and that death occurred at 1:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Luther Bare M.D. ADDRESS (Street, city or town, state): Westminster, Maryland DATE SIGNED: 9/26/57

PHYSICIAN'S NAME (Type): S. Luther Bare 79 W. Main St. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-28-57
22c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
22d. LOCATION (City, town, or county) (State): Gamber, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R. Byers ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR DATE: 9-28-57
24b. REGISTRAR'S SIGNATURE: Harriet Shriner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9353 CERTIFICATE OF DEATH

Reg. Dist. No. 09359

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 39yrs.7mos.16days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1725 Homestead Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aldyth; Middle: ; Last: LONEY

4. DATE OF DEATH: Month: September; Day: 13; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 18, 1893

9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory hand

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles B. Loney

14. MOTHER'S MAIDEN NAME: Mary Gise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: Weeks

DUE TO
(b): Decubitus ulcer — Weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, hebephrenic type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950, to September 13, 1957, that I last saw the deceased alive on September 12, 1957, and that death occurred at 2:20A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/13/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-14-57
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county): Balto (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J Ruck
ADDRESS: 5305 Harford

24a. REC'D BY REGISTRAR DATE: 9-13-57
24b. REGISTRAR'S SIGNATURE: C Harry Steer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M II/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9354 **CERTIFICATE OF DEATH** 09360 Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 47 W. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Kerr — Last: MILLER

4. DATE OF DEATH: Month: September — Day: 2, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 26, 1892

9. AGE (In years last birthday): 64 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter, mechanic

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis Miller

14. MOTHER'S MAIDEN NAME: Carrie Belle Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: 219-07-1083

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

420.0

DUE TO (b): Arteriosclerotic heart disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Generalized arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a): C.B.S. associated with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from September 1, 1957 to September 2, 1957, that I last saw the deceased alive on September 2, 1957, and that death occurred at 5:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/3/57

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: SEPT. 5. 1957

22c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEM.

22d LOCATION (City, town, or county) (State): WESTMINSTER MD

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leavid C. Bankard Westminster, Md

24a. REC'D BY REGISTRAR DATE: SEP 9

24b REGISTRAR'S SIGNATURE: C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pa[illegible] may be retained by the hospital or attending physician.

TO FUN[illegible] DIRECTOR: After this certificate has been signed by the attending physician and completely fill[illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09361

9355

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
c. LENGTH OF STAY IN 1b: 6 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RURAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR.
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY Middle AMELIA Last MYERS

4. DATE OF DEATH: Month SEPT Day 23 Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR 1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: DANIEL W. MYERS

14. MOTHER'S MAIDEN NAME: DOROTHY KING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: DANIEL JONES Address: LINWOOD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Vascular Debility — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
4343
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) General arteriosclerosis — 2 yrs
DUE TO
(c) Cardiac decompensation — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1957, to 9-23-, 1957, that I last saw the deceased alive on 9-18-, 1957, and that death occurred at 1:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Stone M.D. ADDRESS (Street, city or town, state): 121 E. Green St. Westminster DATE SIGNED

PHYSICIAN'S NAME (Type): W. C. Stone WESTMINSTER MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/25/57
22c. NAME OF CEMETERY OR CREMATORY: WESTERN CHAPEL
22d LOCATION (City, town, or county) (State): CARROLL COUNTY MD

23. FUNERAL DIRECTOR'S SIGNATURE: D. D. Hartle & Sons ADDRESS: New Windsor, Md.

24a. REC'D BY REGISTRAR DATE: Sept 24 '57

24b REGISTRAR'S SIGNATURE: Grace S. Bennett
2nd Reg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9356 **CERTIFICATE OF DEATH** 09362

Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1mo.17days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 31
d. STREET ADDRESS: 302 S. Wolfe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William — Middle Albert — Last MYERS

4. DATE OF DEATH: Month September — Day 10, — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 15, 1879
9 AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Myers
14. MOTHER'S MAIDEN NAME: Lucy Myers

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Spanish American
16. SOCIAL SECURITY NO.: -
17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Generalized arteriosclerosis — Years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of liver.- C.P.S.asspciated with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 23, 1957, to September 10 1957 that I last saw the deceased alive on September 10, 1957, and that death occurred at 2:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/10/57

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Sept 13, 1957
22c. NAME OF CEMETERY OR CREMATORY: Baltimore
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lilly & Zeiler Inc. 903 S. Wolfe St
24a. REC'D BY REGISTRAR DATE: 9/11/57
24b. REGISTRAR'S SIGNATURE: C. Harry Heer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9357

CERTIFICATE OF DEATH

09363 74
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3mos.1day
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 208 S. Futaw Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Reginald; Middle Mitchell; Last NAUGHTON
4. DATE OF DEATH: Month September; Day 6; Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 1900
9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ritchie Naughton
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): -
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Carcinoma of the lung
162X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute brain syndrome associated with alcoholism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m.; Month; Day; Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 5, 1957 to September 6, 1957, that I last saw the deceased alive on September 6, 1957, and that death occurred at 1:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/6/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): ✓
22b. DATE THEREOF: 9 19 57
22c. NAME OF CEMETERY OR CREMATORY: Md. Memorial Park Board
22d. LOCATION (City, town, or county) (State): Baltimore, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Frank H. Newell — ADDRESS: Pikesville, Md.
24a. REC'D BY REGISTRAR DATE: SEP 16 1957
24b. REGISTRAR'S SIGNATURE: C. Harry Heep

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

Item 18 Film 221 10-7-57 ams

9358

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09364 81

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Bridge
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alexander Nursing Home

2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Keymar
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: T — Last: Newman

4. DATE OF DEATH: Month: Sept. — Day: 26 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1887

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk

10b. KIND OF BUSINESS OR INDUSTRY: General Store

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John C. Newman

14. MOTHER'S MAIDEN NAME: Allie M. Bowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Thomas Muse — Address: 9 Fair Ave—Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
731 ×
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pathological Fracture of Bone
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan., 1957 to Sept. 26, 1957, that I last saw the deceased alive on Sept. 26, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: J. H. Messler M.D.

PHYSICIAN'S NAME (Type): J. H. MESSLER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 28, 1957

22c. NAME OF CEMETERY OR CREMATORY: Haugh's Cemetery

22d. LOCATION (City, town, or county) (State): Rural Ladiesburg Md

23. FUNERAL DIRECTOR'S SIGNATURE: C. O. Fuss & Son — Merwyn C. Fuss
ADDRESS: Taneytown, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 30 1957

24b. REGISTRAR'S SIGNATURE: Lucile Copp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09365

CERTIFICATE OF DEATH

9359

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 11mos.18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3417 E. Fairmont Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Albert — Middle Frantz — Last PAFEL

4. DATE OF DEATH: Month September — Day 10, — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 31, 1886

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO: 217-20-8289A

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — Years

DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with circ.dist.,with cerebral arteriosclerosis,with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 22, 1956, to Sept. 10, 1957, that I last saw the deceased alive on Sept. 9, 1956, and that death occurred at 8:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/10/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept13,1957
22c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HENRY SANDER & SONS INC. BALTIMORE MD.

24a. REC'D BY REGISTRAR — DATE: Sept.10,

24b. REGISTRAR'S SIGNATURE: ~~Weer & Haight~~ C. Harry Weer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09366

CERTIFICATE OF DEATH

Reg. Dist. No. 74

9360

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 22yrs, 3 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 806 Bradford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John; Middle; Last PODRASKY

4. DATE OF DEATH: Month September; Day 1; Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 17, 1900

9. AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer, clerk

10b. KIND OF BUSINESS OR INDUSTRY: unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Podrasky

14. MOTHER'S MAIDEN NAME: Anna Pottgieser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT: Springfield Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, hebephrenic type. Old pulmonary tuberculosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to September 1 1957, that I last saw the deceased alive on September 1, 1957, and that death occurred at 1:55 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED
PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-4-57
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City or town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight
ADDRESS: Sykesville, Md

24a. REC'D BY REGISTRAR DATE: 9-4-57
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9361 **CERTIFICATE OF DEATH** 09367 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]

c. LENGTH OF STAY IN 1b [illegible]

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]

d NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH Month [illegible] Day [illegible] Year 19

5. SEX M

6. COLOR OR RACE [illegible]

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH [illegible]

9. AGE (In years last birthday) [illegible] yrs

IF UNDER 1 YEAR Months [illegible] Days [illegible]

IF UNDER 24 HRS. Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]

10b KIND OF BUSINESS OR INDUSTRY [illegible]

11. BIRTHPLACE (State or foreign country) [illegible]

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible]

14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address [illegible]

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 hours

DUE TO (b) Amyotrophic Lateral Sclerosis — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/14, 19[illegible], to 9/14, 19[illegible], that I last saw the deceased alive on 9/14, 19[illegible], and that death occurred at [illegible] M. from the causes and on the date stated above.

ACTUAL SIGNATURE S. Luther Bare M.D. — ADDRESS (Street, city or town, state) [illegible] — DATE SIGNED [illegible]

PHYSICIAN'S NAME (Type) S. LUTHER BARE — Westminster Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) [illegible]

22b. DATE THEREOF 9-23-57

22c. NAME OF CEMETERY OR CREMATORY [illegible]

22d LOCATION (City, town, or county) (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] — ADDRESS [illegible]

24a. REC'D BY REGISTRAR DATE 9-24-57

24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09368

9362

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural New Windsor
c. LENGTH OF STAY IN 1b: 40yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural New Windsor
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harvey Middle: Ernest Last: Roser

4. DATE OF DEATH: Month: Sept. Day: 3 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov, 26, 1888

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Roser

14. MOTHER'S MAIDEN NAME: Alice Harp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-24-5766

17. INFORMANT: Address: Mrs. Nora Roser, New Windsor, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 Minutes

420.1

DUE TO (b): Angina Pectaris — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 30, 19 56, to Sept. 3, 19 57, that I last saw the deceased alive on aug 28, 19 57, and that death occurred at 7 30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D. ADDRESS (Street, city or town, state): New Windsor, Md. DATE SIGNED: 9/3/57

PHYSICIAN'S NAME (Type): M.E.Robertson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 5, 1957

22c. NAME OF CEMETERY OR CREMATORY: Pine Creek Cemetery

22d. LOCATION (City, town, or county) (State): Nr. Uniontown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Merwyn C. Fuss Taneytown, Laryland

24a. REC'D BY REGISTRAR DATE: SEP 5 1957

24b. REGISTRAR'S SIGNATURE: Gracie Benedict

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9363

CERTIFICATE OF DEATH

Reg. Dist. No. 09369

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 26 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 105 South Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Littlestown
d. STREET ADDRESS: Littlestown, Pa. R.D.1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Amelia — Last: Shanebrook
4. DATE OF DEATH: Month: September — Day: 29 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 18, 1870
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife, Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own home.
11. BIRTHPLACE (State or foreign country): Adams County, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: P. David Schwartz
14. MOTHER'S MAIDEN NAME: Eliza Jane Plank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Rev. Richard S. Shanebrook. Address: Rev. Richard S. Shanebrook, Manchester, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral
DUE TO (b): old age
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
450.0
INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/4/57, 19 57, to 9/27/57, 19 57, that I last saw the deceased alive on 9/21/57, 19 57, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. H. Foard, M.D. ADDRESS (Street, city or town, state): Manchester, Md. DATE SIGNED: 9/29/57
PHYSICIAN'S NAME (Type): W. H. Foard, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/1/57
22c. NAME OF CEMETERY OR CREMATORY: St. Lukes Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Littlestown, Adams Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Tatle — ADDRESS: Littlestown, Pa.
24a. REC'D BY REGISTRAR DATE: Sept 30
24b. REGISTRAR'S SIGNATURE: Mrs. H. P. Denner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9364 **CERTIFICATE OF DEATH** 09370 74

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville

c. LENGTH OF STAY IN 1b: 1 y 6 m 19 d

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d STREET ADDRESS: 10115 Greenock Rd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle Cabell Last Sheehy

4 DATE OF DEATH: Month 9 Day 21 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-28-79

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ~~Maryland~~ Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward J. Sheehy

14 MOTHER'S MAIDEN NAME: (unknown) Reidy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unkn (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT Address: S.S.Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis — years

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr.brain syndr.assoc. with cerebral arterioscler. with psych. react

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9-2-56 19__, to 9-21- 19 57, that I last saw the deceased alive on 9-21- 1957, and that death occurred at 11 A M, from the causes and on the date stated above

ACTUAL SIGNATURE: Edmund B. Lusthaus M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 9-21-57

NAME (Type): Edmund B. Lusthaus Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/24/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward L. Humphrey ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: SEP 24 1957

24b REGISTRAR'S SIGNATURE: C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Bill (620) 8-13-57 et

9365

CERTIFICATE OF DEATH

09371

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 7yrs.10mos.29days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: 323 S. Castle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Barbara; Middle: ; Last: SMITH
4. DATE OF DEATH: Month: September; Day: 4; Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ (Widowed)
8. DATE OF BIRTH: August 25, 1881
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael Fondron
14. MOTHER'S MAIDEN NAME: Elizabeth Baum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: 216-16-9900
17. INFORMANT: Springfield Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Generalized arteriosclerosis — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with cerebral arteriosclerosis and pulmonary tuberculosis, inactive.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950 to September 4, 1957 that I last saw the deceased alive on September 3, 1957, and that death occurred at 6:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 9/4/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 7, 1957
22c. NAME OF CEMETERY OR CREMATORY: St. Matthews
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lilly + Zeiler Inc., 403 S. Wolfe St.
24a. REC'D BY REGISTRAR DATE: 9/6/57
24b. REGISTRAR'S SIGNATURE: C. Harry Thorp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09372

9366

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED
COUNTY Carroll — MARYLAND	STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Union Bridge — LENGTH OF STAY (in this place): 55 years	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Union Bridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rhoda L. Smith	Sept. 26, 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
F	W	Widow	April 8, 1881	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Scott McAlester	Annamary Boone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	none	Carroll R. Smith, Point Pleasant, N.J.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	Carcinomatosis	8 mos —
ANTECEDENT CAUSE(S) DUE TO (B)	Carcinoma Colon	8 mos.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4-13-57	Carcinoma Colon - Metastasis abdominal wall & abdominal viscera	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 7, 1957, to Sept 26, 1957, that I last saw the deceased alive on Sept 25, 1957, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE James J. Monagle M.D. ADDRESS (Street, city, town, state) Westminster Md DATE SIGNED 9/26/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/28/57	Lutheran Cemetery	Uniontown, Maryland

24. REC'D BY REGISTRAR DATE SEP 28 1957	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
	Leslie L. Repp	Merwyn C. Fuss Taneytown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9367

09373

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington 15X
d. STREET ADDRESS: 4414 Brookfield Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Victorine Emilie — Middle: L'Homme — Last: SMITH

4. DATE OF DEATH: Month: September — Day: 25, — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 10, 1877

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): France

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emile L'Homme

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO: --

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

471X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from September 13, 1957 to September 25, 1957, that I last saw the deceased alive on September 24, 1957, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 9/25/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 9/28/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. RECD BY REGISTRAR DATE: SEP 26 1957

24b. REGISTRAR'S SIGNATURE: Mary Mae

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09374

9368 **CERTIFICATE OF DEATH**

Reg. Dist. No. 50

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle LOU Last SNADER

4. DATE OF DEATH: Month SEPT. Day 13 Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/28/1873

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ELHANNAN ENGLAR

14. MOTHER'S MAIDEN NAME: MARGARET BUCKEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: PHILIP B. SNADER, NEW WINDSOR MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute enteritis
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-10-, 1957, to Sept 13, 1957, that I last saw the deceased alive on Sept. 13, 1957, and that death occurred at 8 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. N Legg M.D.

ADDRESS (Street, city or town, state): Union Bridge Md

DATE SIGNED: 9-14-57

PHYSICIAN'S NAME (Type): Thomas H. Legg, M.D. Union Bridge, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9/16/57

22c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK CEM

22d. LOCATION (City, town, or county) (State): CARROLL COUNTY MD

23. FUNERAL DIRECTOR'S SIGNATURE: D. O. Hartzler & Sons

ADDRESS: NEW WINDSOR MD

24a. RECD BY REGISTRAR DATE: Sept 14 57

24b. REGISTRAR'S SIGNATURE: Grace R Benedict

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09375

9369

CERTIFICATE OF DEATH

Reg. Dist. No. 17

1. PLACE OF DEATH
a. COUNTY: CARROLL CO. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER
c. LENGTH OF STAY IN 1b: 1 WEEK
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: OLD BALTIMORE ROAD

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: PENNA.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ALTOONA
d. STREET ADDRESS: 115 LADIS, ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALICE Middle LORRAINE Last STANDER

4. DATE OF DEATH: Month SEPT. Day 9 Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 29, 1901

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): CARROLL CO,

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES ALBERT PEELING

14. MOTHER'S MAIDEN NAME: STELLA BARNES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown). (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO. —

17. INFORMANT Address: ALISON PEELING, WESTMINSTER, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Squamous Carcinoma Abdomen — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b): Metastases from Carcinoma Uterus — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/5/57, 19 57, to 9/8, 19 57, that I last saw the deceased alive on 9/8, 19 57, and that death occurred at 1P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Luther Bare M.D. ADDRESS (Street, city or town, state): Westminster Maryland DATE SIGNED: 9/9/57

PHYSICIAN'S NAME (Type): S. LUTHER BARE

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT. 11 57

22c. NAME OF CEMETERY OR CREMATORY: FINKSBURG CEM.

22d LOCATION (City, town, or county) (State): FINKSBURG, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers ADDRESS: W. Westminster, Md

24a. REC'D BY REGISTRAR DATE 9-11-57

24b. REGISTRAR'S SIGNATURE: Harriet Fuller

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9379 **CERTIFICATE OF DEATH** 09376 Reg. Dist. No. 16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: CARROLL	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: MD b. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-WESTMINSTER c. LENGTH OF STAY IN 1b: 59 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-WESTMINSTER
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RD 7	d. STREET ADDRESS: RD 7 e. IS RESIDENCE ON A FARM? YES ☒ NO ☐
3. NAME OF DECEASED (Type or print): First ARTHUR Middle DIEHL Last STARNER	4. DATE OF DEATH: Month SEPT. Day 17 Year 1957
5. SEX: M	6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 12-21-1897
9. AGE (In years last birthday): 59 yrs	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER	10b. KIND OF BUSINESS OR INDUSTRY: DAIRY
11. BIRTHPLACE (State or foreign country): MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JACOB D. STARNER	14. MOTHER'S MAIDEN NAME: JESSIE DATHOFF
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 214-01-0558
17. INFORMANT: BESSIE M. STARNER	Address: RD 7 WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few minutes
DUE TO
(b): Arteriosclerosis (Gen'l) — several yrs
DUE TO
(c): Diabetes mellitus — many yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from August 19 57 to Sept 17, 19 57, that I last saw the deceased alive on Aug 3, 19 57, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm Lewis Speicher ADDRESS (Street, city or town, state): Westminster Md DATE SIGNED: 9/15/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	22b. DATE THEREOF: 9-21-1957	22c. NAME OF CEMETERY OR CREMATORY: KRIDERS C.E.M.	22d. LOCATION (City, town, or county) (State): WESTMINSTER, MD	
23. FUNERAL DIRECTOR'S SIGNATURE: David C Bankard	ADDRESS: Westminster Md.	24a. REC'D BY REGISTRAR DATE: 9-20-57	24b. REGISTRAR'S SIGNATURE: Harriet Conaway	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 3-13-[illegible] 7-23-7 et

9371

CERTIFICATE OF DEATH

09377

Reg. Dist. No. 714

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 11 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 29 Murdock Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: William — Last: Vandersloot

4. DATE OF DEATH: Month: 9 — Day: 14 — Year: 1957

5. SEX: Male — MX F/

6. COLOR OR RACE: W W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-27-02

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): filling machine helper

10b. KIND OF BUSINESS OR INDUSTRY: Mattress Co

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward R. Vandersloot

14. MOTHER'S MAIDEN NAME: Elsie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: Unkn

17. INFORMANT — Address: S.S.Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Obstructive biliary cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: months

584-X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Calculus of gall bladder — months

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Manic depressive psychosis, Hypomanic phase

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-14-, 1956, to 9-13-, 1957, that I last saw the deceased alive on 9-13-, 1957, and that death occurred at 3:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus, M.D. — ADDRESS (Street, city or town, state): Springfield StateHospital — DATE SIGNED: 9-14-57

PHYSICIAN'S NAME (Type): Edmund Lusthaus — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT-17,1957

22c. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE

22d. LOCATION (City, town, or county) (State): BALTIMORE, MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. M. Cook-Towson, Inc-Towson 4, Md.

24a. REC'D BY REGISTRAR — DATE: 9-14-57

24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9372

CERTIFICATE OF DEATH

093781
Reg. Dist. No. 35

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Old Fork School House Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
d. STREET ADDRESS: Old Fork School House Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Rosie — Middle: Leola — Last: Vaughn

4. DATE OF DEATH: Month: September — Day: 30 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Oct 17 1883

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George T Bean

14. MOTHER'S MAIDEN NAME: Rebecca Warfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: George W Vaughn — Address: Hampstead Rt 1 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Hypertension

DUE TO (c): Arteriosclerotic Heart Disease — 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-1 19 57, to 7-13 19 57, that I last saw the deceased alive on 9-29 19 57, and that death occurred at 1:45 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: W H Foard M D, ADDRESS (Street, city or town, state): Manchester Md — DATE SIGNED: 9/30/57

PHYSICIAN'S NAME (Type): W H Foard M D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 2 1957
22c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery
22d. LOCATION (City, town, or county) (State): Reisterstown Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Berryman & Sons — ADDRESS: Reisterstown Md

24a. REC'D BY REGISTRAR — DATE: 9-30-57

24b. REGISTRAR'S SIGNATURE: Mary B. Shaw

Mrs. W. H. Foard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9373

CERTIFICATE OF DEATH

09379 81
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: BROADWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: BROADWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VINNIE Middle CAROLINE Last WAREHIME

4. DATE OF DEATH: Month SEPT Day 30 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/17/1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SAMUEL BENEDICT

14. MOTHER'S MAIDEN NAME: LAVINIA BENEDICT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: GLENN WAREHIME Address: KEYMAR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardio Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH: years

442X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10 19 57 to Sept 30 19 57 that I last saw the deceased alive on Sept 25 19 57 and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Marsh M.D. ADDRESS (Street, city or town, state): 105 E Main St DATE SIGNED: 10/1/57

PHYSICIAN'S NAME (Type): JAMES T. MARSH Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: OCT 2 1957

22c. NAME OF CEMETERY OR CREMATORY: BAUST CEM.

22d. LOCATION (City, town, or county) (State): CARROLL CO MD

23. FUNERAL DIRECTOR'S SIGNATURE: DD Hartzler & Sons ADDRESS: Union Bridge Md

24a. REC'D BY REGISTRAR DATE: 10/2/57

24b. REGISTRAR'S SIGNATURE: Leslie L. Repp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9374 CERTIFICATE OF DEATH

Reg. Dist. No. 09389

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
c. LENGTH OF STAY IN 1b: 70 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural -- Mt. Airy x2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ISAAC Middle M. Last WATERS

4. DATE OF DEATH: Month Sept. Day 3, Year 1957

5. SEX: male

6. COLOR OR RACE: negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-6-1870

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Misc.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard Waters

14. MOTHER'S MAIDEN NAME: Elizabeth Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Roberta Dorsey, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chron. Nephritis with Uremic Uricity — INTERVAL BETWEEN ONSET AND DEATH

592X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ? Arteriosclerosis

DUE TO (c): Acute Cardiac Failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 31, 1957 to Sept 3, 1957, that I last saw the deceased alive on Aug 31, 1957, and that death occurred at 2 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C M Van Poole M.D. ADDRESS (Street, city or town, state): Mt Airy Md DATE SIGNED: 9-4-57

PHYSICIAN'S NAME (Type): C M Van Poole

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9-7-1957

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Mt. Zion

22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 9 1957

24b. REGISTRAR'S SIGNATURE: Edna Hurley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09381

9375 **CERTIFICATE OF DEATH**

Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: Since 4-25-52
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, 3 V o l - 4
d. STREET ADDRESS: 120 Cheapside Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George; Middle; Last YANIK
4. DATE OF DEATH: Month September; Day 9; Year 19 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unk
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Andrew Yanik
14. MOTHER'S MAIDEN NAME: Annie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Springfield State Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
434.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with cerebral arteriosclerosis.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 4-25, 1957, to 9-9, 19 57, that I last saw the deceased alive on September 9, 19 57, and that death occurred at 2:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): Martin Gross, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-12-57
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: 9-12-57
24b. REGISTRAR'S SIGNATURE: C. Haight Uhler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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